Part 2: Provider Information

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Section 2.1: Approval Process

All components of the New Provider Proposal Packet (listed below) must be completed in order for an application to be considered. If any portion of the packet is incomplete, the proposal will be denied. Prospective providers may submit a proposal year round. Please see http://www.in.gov/fssa/ddrs/2644.htm for further information.

Proposals should be submitted to:
Director of Provider Relations
DDRS- Division of Disability and Rehabilitative Services
402 W. Washington St., RM 453, MS 18
Indianapolis, IN 46207
BDDSprovider@fssa.IN.gov

Bureau of Developmental Disabilities Services (BDDS) New Provider Proposal Packet

The packet consists of the documents listed below, two of which pertain only to Case Management services. Open and print each of them to complete the packet. Reference material is also provided below.

- Application for Approval to Become a Provider of BDDS Services for Individuals with Developmental Disabilities
- Case Management Services Checklist
- Case Management Surety Bond form
- DDRS HCBS Provider Requirements Checklist
- FSSA Provider Data Form
- State of Indiana Automated Direct Deposit Authorization Agreement
- DDRS Provider Agreement
- Taxpayer Identification Request Form, W-9

References

- DDRS Policies: http://www.in.gov/fssa/ddrs/3340.htm
- Waiver Service Definitions – PART 10 of the DDRS Waiver Manual
- Nurse Aide Registry: https://mylicense.in.gov/EVerification/Search.aspx

Section 2.2: Requirements for Providers of Case Management

Requirements specific to Case Management and the minimum qualifications of Case Managers are found in the *Case Management Services Checklist* as well as in **PART 10: Section 10.31** of this manual.

Additional information for prospective providers of Case Management services may be found on the Bureau of Developmental Disabilities Provider Relations page at http://www.in.gov/fssa/ddrs/2644.htm and includes the following:

- Application for Approval to Become a Provider of BDDS Services for Individuals with Developmental Disabilities
- Case Management Services Checklist
- Case Management Surety Bond form
- FSSA Provider Data Form
- State of Indiana Automated Direct Deposit Authorization Agreement
- DDRS Provider Agreement
- Provider Request to Add Counties and Services

NOTE: Providers of Case Management services may not provide any other waiver funded services.

Section 2.3: Requirements for all Providers (excluding Case Management)

All Waiver Service providers must meet the general requirements outlined in within the DDRS HCBS Provider Requirements Checklist to gain approval and to remain in approved status. The requirements address the following categories:

- Legal Documents
- Insurance Coverage
- Organizational Chart
- Proof of Managerial Ability
- General administrative requirements for providers that include, but are not limited to, compliance with Medicaid and Medicaid Waivers, collaboration and quality control and quality assurance.
- Financial status for providers documenting financial stability and other fiscal issues.
- Professional qualifications and requirements, including but not limited to, requirements for qualified personnel and training requirements. Please review DDRS's HCBS Provider Requirements Checklist's Policy Section for a detailed list of all the policies providers are required to have in place prior to offering services to consumers. Requirements vary to

some extent depending on the specific services applicants wish to be approved to provide.

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Section 2.4: Provider Re-Approval

The Division of Disability and Rehabilitative Services (DDRS) routinely reviews the performance of all of its Medicaid Home and Community Based Services (HCBS) waiver providers and makes re-approval determinations at least once every three years. Providers may be re-approved for terms of 6, 12, or 36 months.

DDRS's Bureau of Quality Improvement Services (BQIS) initiates the re-approval process and evaluates the following information for each provider:

- Findings from provider's compliance review;
- Findings from provider's accreditation review;
- Numbers of complaints BQIS has received about the provider and numbers of substantiated allegations;
- Patterns in provider's sentinel incident reports;
- Numbers of and types of incident reports related to abuse, neglect, and exploitation, medical, and behavioral issues; and
- Any other information DDRS deems necessary to assess a provider's performance.

Every new provider will receive at least one provider compliance review in its initial term. BQIS conducts this review using the Compliance Evaluation Review Tool (CERT) which looks at:

- Provider's qualifications;
- Required policies being in place;
- Staff records containing documentation of required general qualifications and training; and
- Evidence of the provider's quality assurance/quality improvement system being implemented.

Residential habilitation, day program, and case management providers are required to be accredited by any of the following accreditation entities

- The Commission on Accreditation of Rehabilitation Facilities (CARF)

- The Council on Quality and Leadership in Supports for People with Disabilities (CQL)
- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- The ISO-9001 Quality Management System
- The Council on Accreditation (COA)

Although case management providers are not permitted to provide any other waiver services, residential and day program providers may choose to obtain accreditation for other waiver services that they are approved to provide, however this is not required. Some accreditation entities accredit the organization, whereas others allow providers to select the services they wish to accredit. BQIS will not conduct compliance reviews on any accredited services. This means if a provider chooses to accredit only some of its services, BQIS will continue to conduct provider compliance reviews on all of the provider's non-accredited services. All services will be reviewed at least once every three years, either by BQIS or the accreditation entity of the provider's choosing.

The process for re-approving providers is outlined in DDRS's Policy on Provider Re-Approvals http://www.in.gov/fssa/files/Provider_Reapproval.pdf. Further information on the re-approval process and its related tools are available on BDDS Provider Relations' web page at http://www.in.gov/fssa/ddrs/2644.htm

Based on BQIS's input, the Division of Disability and Rehabilitative Services' Bureau of Developmental Disabilities Services (BDDS) Director of Provider Relations will issue providers notices of 6, 12, or 36 month re-approval terms with explicit instructions that the re-approval term is contingent upon the provider submitting the following information within 30 days:

- Signed provider agreement
- Accreditation entity's letter identifying the specific services that have been accredited;
- Most recent accreditation report; and
- Accreditation entity's report of areas requiring corrective action.

BDDS Provider Relations **MUST** receive all of these documents prior to the provider's re-approval term beginning.

If a provider fails to return a Provider Agreement and/or the Accreditation information within thirty (30) days, the provider has failed to meet the requirements for re-approval and will receive a letter indicating that it is under a six (6) month probationary approval and may be referred to the DDRS Sanctions Committee for a potential moratorium on new admissions and/or civil sanctions.

- At the end of the six (6) month probationary period, the provider must repeat DDRS's provider re-approval process again and provide all of the required data

analysis and systems descriptions for how it can assure the quality of services being delivered.

All re-approval determinations may go before the DDRS Provider Review Committee for final re-approval decisions.

Administrative Review:

- To qualify for administrative review of a DDRS order, a provider shall file a written petition for review that does the following:
    - States facts demonstrating that the provider is:
        - a provider to whom the action is specifically directed;
        - aggrieved or adversely affected by the action; or
        - entitled to review under any law.
    - Is filed with the director of DDRS within fifteen (15) days after the provider receives notice of the sanctioning order.
- Administrative review shall be conducted in accordance with IC 4-21.5-3-7.

A provider adversely affected or aggrieved by BDDS' determination may request administrative review of the determination, in writing, within fifteen (15) days of receiving the notification.

If a provider has complied with the renewal timelines and if the BDDS does not act upon a provider's request for renewal of approved status before expiration of the provider's approved status, the provider will continue in approved status until such time as the BDDS acts upon the provider's request for renewal of approved services.

Section 2.5: Claims and Billing

Waiver Authorization

The waiver Case Manager is responsible for completing the Plan of Care/Cost Comparison Budget (CCB), which, upon approval by the State, results in an approved Notice of Action (NOA). The NOA details the services and number of units to be provided, the name of the authorized provider, and the approved billing code with the appropriate modifiers. The case manager transmits this information to the waiver database (INsite). INsite communicates this data to Indiana*AIM* where it is stored in the prior authorization database. Claims will deny if no authorization exists in the database or if a code other than the approved code is billed. Providers are not to render or bill services without an approved NOA. It is the provider's

responsibility to contact the case manager in the event there is any discrepancy in the services authorized or rendered and the approved NOA.

Claim Tips and Reminders

When billing Medicaid waiver claims, the provider must consider the following:

- **The IHCP does not reimburse time spent by office staff billing claims.**
- Providers may only bill for those services authorized on an approved NOA.
- A claim may include dates of service within the same month. Do not submit a claim with dates that span across more than one month on the same claim.
- The units of service as billed to the IHCP must be substantiated by documentation in accordance with the appropriate Indiana Administrative Code (IAC) regulations and the waiver documentation standards issued by the OMPP and the Division of Disability and Rehabilitative Services (DDRS).
- Services billed to the IHCP must meet the service definitions and parameters as published in the aforementioned rules and standards.
- Updated information is disseminated through IHCP provider bulletins posted on indianamedicaid.com and/or the DDRS website at http://www.in.gov/fssa/2328.htm . Each provider is responsible for obtaining the information and implementing new or revised policies and procedures as outlined in these notices.